

**APPENDIX 3
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS
FOR HEALTHCHECK SERVICES**

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAF) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "H" for the service billed in the Medicaid check box when billing using local codes for claims received before 7/1/95. Enter claim sort indicator "P" when billing using CPT codes. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER

Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME

Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS

Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Health insurance (commercial insurance coverage) must be billed prior to billing the WMAF, unless the service does not require health insurance billing according to Appendix 18a of Part A of the WMAF Provider Handbook.

- When the provider has not billed health insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the WMAF Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.
- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires health insurance according to Appendix 18a of Part A of the WMAF Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c and 9d are not required.)

<u>Code</u>	<u>Description</u>
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|------|--|
| OI-P | PAID in part by <u>health</u> insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim. |
| OI-D | DENIED by <u>health</u> insurance following submission of a correct and complete claim or payment was applied toward the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer. |
| OI-Y | YES, card indicates other coverage but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none">- Recipient denies coverage or will not cooperate;- The provider knows the service in question is noncovered by the carrier- Insurance failed to respond to initial and follow-up claim; or- Benefits not assignable or cannot get an assignment. |

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

<u>Code</u>	<u>Description</u>
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|------|---|
| OI-P | PAID by HMO or HMP. The amount paid is indicated on the claim. |
| OI-H | HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount. |

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAF except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAF for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER

The first box of this element is used by the WMAF for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAF. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

<u>Code</u>	<u>Description</u>
M-1	Medicare benefits exhausted. May be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAF Provider Handbook for further information regarding the submission of claims for dual entitlements.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE

(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (not required)

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN (not required)

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE

If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. When a specific medical diagnosis has not been determined, indicate diagnosis code V70.0 (routine general medical examination at health care facility). The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION (not required)

ELEMENT 24A - DATE(S) OF SERVICE

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

ELEMENT 24B - PLACE OF SERVICE

Enter the appropriate WMAF single-digit place of service code for each service. Refer to Appendix 18a and 18b of this handbook for allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE

Enter the appropriate single-digit type of service code. Refer to Appendix 18a and 18b of this handbook for allowable type of service codes.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 1, 1a and 1b of this handbook for a list of allowable procedure codes and to Appendix 2a and 2b for a list of allowable modifiers. See Appendices 18a and 18b for procedure codes with corresponding modifiers, place of service, type of service codes, and claim sort indicators.

ELEMENT 24E - DIAGNOSIS CODE

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES

Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS

Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG

Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE

Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33. This element is not required for HealthCheck nursing agencies.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAF Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT

(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE AND PHONE #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.